HB 1272

Department of Legislative Services

Maryland General Assembly
2016 Session

FISCAL AND POLICY NOTE
First Reader

House Bill 1272 (Delegate Pendergrass)
Health and Government Operations

Health - Collaborations to Promote Provider Alignment

This bill exempts "collaborations to promote provider alignment" from general prohibitions against self-referrals by health care practitioners and required disclosures of beneficial interests. "Collaborations to promote provider alignment" means collaborations that (1) involve the distribution, either directly or indirectly through a contract, of compensation that is attributable to specified arrangements or value-based payment models; (2) promote accountability for the overall care of patients; and (3) encourage investment in redesigned care processes for high quality and efficient service delivery to patients. The purpose of collaborations is to promote provider alignment to achieve the goals of Maryland's all-payer model contract. The bill may not be construed to affect existing exceptions to self-referral or specified definitions under State law.

Fiscal Summary

State Effect: To the extent collaborations result in reduced avoidable utilization of health care services, expenditures for Medicaid (60% federal funds, 40% general funds) and the State Employee and Retiree Health and Welfare Benefits Program may decrease. Federal Medicaid matching fund revenues decline correspondingly.

Local Effect: The bill does not directly affect local government finances or operations.

Small Business Effect: Potential meaningful.

Analysis

Bill Summary: "Health care entity" means a business entity that provides specified health care services. "Health care practitioner" means a person who is licensed, certified, or otherwise authorized under the Health Occupations Article to provide health care services.

"Risk-bearing health care entity" includes (1) a licensed acute care hospital; (2) an academic medical center; (3) a health care entity that accepts a prospectively determined payment for certain services and quality outcomes; or (4) any organization that meets the criteria for an accountable care organization established by the U.S. Department of Health and Human Services.

Current Law: Under the Health Occupations Article, a health care practitioner may not refer a patient, or direct an employee or a person under contract with the health care practitioner to refer a patient, to a health care entity (1) in which the health care practitioner or the practitioner in combination with the practitioner's immediate family owns a beneficial interest; (2) in which the practitioner's immediate family owns a beneficial interest of 3% or greater; or (3) with which the health care practitioner, the practitioner's immediate family, or the practitioner in combination with the practitioner's immediate family has a compensation arrangement.

However, this prohibition does not apply to a health care practitioner who refers in-office ancillary services or tests that are (1) personally furnished by the referring health care practitioner, a health care practitioner in the same group practice as the referring health care practitioner, or an individual who is employed and personally supervised by the qualified referring health care practitioner or a health care practitioner in the same group practice as the referring health care practitioner; (2) provided in the same building where the referring health care practitioner or a health care practitioner in the same group practice as the referring health care practitioner furnishes services; and (3) billed by the health care practitioner performing or supervising the services or a group practice of which the health care practitioner performing or supervising the services is a member.

"In-office ancillary services" is defined as those basic health care services and tests routinely performed in the office of one or more health care practitioners; except for a radiologist group practice or an office consisting solely of one or more radiologists, in-office ancillary services do not include magnetic resonance imaging services, radiation therapy services, or computer tomography scan services.

Under the Insurance Article, each individual or group health insurance policy issued in the State by an entity must include a provision that excludes payment of any claim, bill, or other demand or request for payment for health care services that the appropriate regulatory board determines were provided as a result of a prohibited referral. An entity may seek

repayment from a health care practitioner for any money paid for a claim, bill, or other demand or request for payment for health care services that were provided as a result of a prohibited referral. Additionally, an entity may seek a refund of a payment made for a claim, bill, or other demand or request for payment that is subsequently determined to be for a health care service provided as a result of a prohibited referral.

Background: In 2015, the Chairman of the House Health and Government Operations Committee requested that the Maryland Health Care Commission (MHCC) convene a Provider-Carrier Workgroup to examine the State's self-referral law for health care practitioners. While the workgroup did not make specific recommendations, it did issue a number of consensus items, including that the law should be modernized to allow for the development of additional bona fide value-based payment models, risk-sharing arrangements, and alignment models and that greater clarity is needed to ensure emerging compensation arrangements are permissible.

Maryland's hospital rate-setting system operates under the Maryland all-payer model, a five-year demonstration contract approved by the federal Center for Medicare and Medicaid Innovation in January 2014, which replaced the State's all-payer, rate-regulated hospital financing system. The model contract includes the following major components:

- **All-payer Total Hospital Cost Growth Ceiling:** Maryland will limit inpatient and outpatient hospital cost growth for all payers by 3.58% for the first three years.
- **Medicare Total Hospital Cost Growth Ceiling:** Maryland will limit Medicare per-beneficiary total hospital cost growth sufficient to produce $330.0 million in cumulative Medicare savings over five years.
- **Population-based Revenue:** Hospital reimbursement will shift from a per-case system to a population-based system.
- **Reduction of Hospital Readmissions:** Maryland will commit to reducing its Medicare readmission rate over five years.
- **Reduction of Hospital Acquired Conditions:** Maryland will achieve an annual aggregate reduction of 6.89% in potentially preventable conditions measures for a cumulative reduction of 30% over five years.

The demonstration will be deemed successful if Maryland can meet the hospital cost and quality targets without inappropriately shifting costs to nonhospital settings *and* if there is a measurable improvement in quality of care.

Small Business Effect: Specified health care entities and health care practitioners that participate in collaborations to promote provider alignment under the bill may benefit from the exemption from current self-referral prohibitions and required beneficial interest

disclosures. The insurance industry may also be affected, since the bill adds an additional exemption that would not be excluded under insurance policies.

Additional Information

Prior Introductions: None.

Cross File: SB 886 (Senator Middleton) - Finance.

Information Source(s): Department of Health and Mental Hygiene, Department of Legislative Services

Fiscal Note History: First Reader - March 3, 2016
min/jc

Analysis by: Sasika Subramaniam

Direct Inquiries to:
(410) 946-5510
(301) 970-5510